ANNUAL REGULATORY BURDEN REPORT

NOVEMBER 2023

CONTENTS

INTRODUCTION

The results of the Medical Group Management Association's (MGMA) Annual Regulatory Burden Survey reveal that medical practices continue to face overwhelming regulatory challenges. In many cases, the burden has increased year over year. This year's annual report highlights the ongoing burden associated with prior authorization and the Medicare Quality Payment Program faced by medical groups, leading to a struggle to maintain access for patients with traditional Medicare.

From measuring quality to completing prior authorization requirements, medical practices face mounting regulatory hurdles that interfere with clinical goals and improving patient outcomes. The Annual Regulatory Burden Survey provides MGMA with critical data on the real impact of federal policies and regulations, allowing us to better educate Congress and the Administration about obstacles to delivering high-quality patient care.

This year's survey responses demonstrate that there is still much to be done at the federal level to provide regulatory relief for medical groups. MGMA will continue to play a key role in the policy discussion to ensure that medical practices have a voice in Washington.

About the Respondents

The survey includes responses from executives representing over 350 group practices. Sixty percent of respondents are in practices with less than 20 physicians and 16% are in practices with over 100 physicians. Seventy-five percent of respondents are in independent practices.

About MGMA

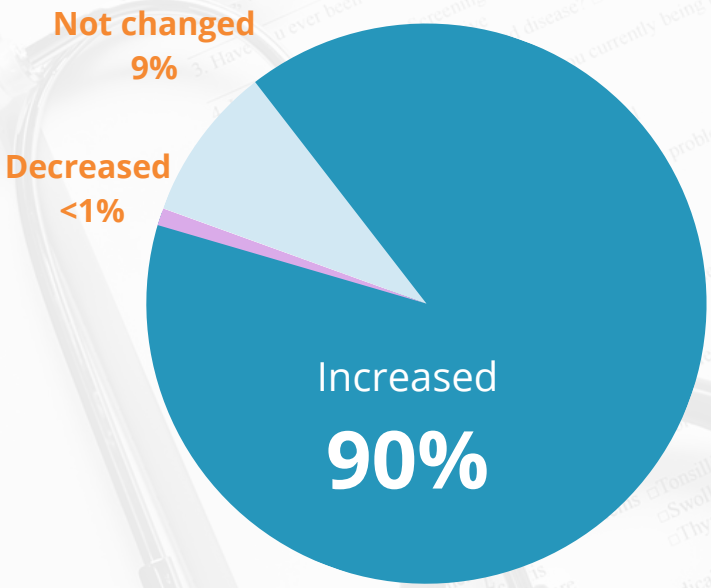
With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups comprising more than 350,000 physicians. These groups range from small independent practices in remote and other underserved areas to large regional and national health systems that cover the full spectrum of physician specialties. For more information on how MGMA is advocating for medical practices in Washington, please visit mgma.com/advocacy or contact us at govaff@mgma.org.

CURRENT STATE OF REGULATORY BURDEN

MGMA has long advocated that policymakers in Washington scale back regulatory burden for medical practices, arguing that these requirements divert time and resources away from delivering patient care. Yet, as indicated in this year's report, regulatory burden continues to rise.

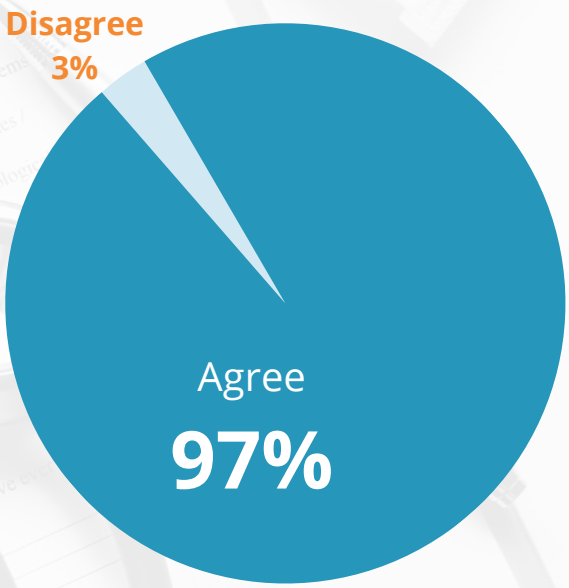
Reducing regulatory requirements that do not improve patient care will assist group practices in focusing on patient care and allow them to invest resources in initiatives that improve healthcare delivery, further clinical priorities, and reduce costs.

The overall regulatory burden on your medical practice over the past 12 months has:*



*Totals do not equal 100% due to rounding

A reduction in regulatory burden would allow you to reallocate resources toward patient care:



What group practices are saying:

"The prior authorization and MIPS requirements are especially burdensome. The good faith estimate requirements have added additional duties, but our Medicare payments keep flat or decrease. This is not sustainable for independent practices. They seem to be a target!"

"As a small, independent, primary care practice, it is very hard to keep up with all the changes. While you can purchase vendors that do credentialing, programs that can reduce your denials, and many other products that can reduce the burden placed on us, we simply cannot afford it."

"The increasing regulatory burdens for MIPS, the No Surprises Act, prior authorization, etc., has not only increased our need for additional staffing, but has also resulted in significant operational losses over the last fiscal year. As an organization, we are now tested with making very difficult decisions regarding staffing and our patient care lines."

BURDEN LEVEL BY REGULATORY ISSUE

How burdensome would you rate each of the following regulatory issues?

	Not burdensome	Slightly burdensome	Moderately burdensome	**Very or extremely burdensome**
Prior authorization	1.61%	1.61%	7.42%	**89.35%**
Audits and appeals	1.34%	7.36%	23.08%	**68.23%**
Medicare Quality Payment Program (MIPS/APMs)	5.41%	7.32%	20.06%	**67.19%**
Surprise billing and good faith estimate requirements	4.78%	7.01%	24.84%	**63.38%**
Medicare Advantage chart audits	3.22%	10.29%	24.76%	**61.73%**
Lack of EHR interoperability	6.49%	14.61%	31.82%	**47.08%**
Translation and interpretation requirements	7.01%	20.38%	30.25%	**42.35%**
Medicare & Medicaid credentialing	7.05%	21.79%	28.85%	**42.31%**

What group practices are saying:

"I went from spending under 5% of my administrative time on compliance per year, to well over 35% of my time trying to keep up to date with the ever-changing rules, implementation, and training staff on said rules. I would rather spend my time coming up with better ways to keep patients as healthy as possible and work with my physicians to continue providing outstanding care to our patients through technology and added value services."

"Providers should not have to employ hundreds of staff to simply jump through all the hoops to properly get paid. Ever-increasing administration burdens, credit card fees, lack of interoperability, reliance on faxing, etc., makes medical office administration ridiculously and needlessly complex."

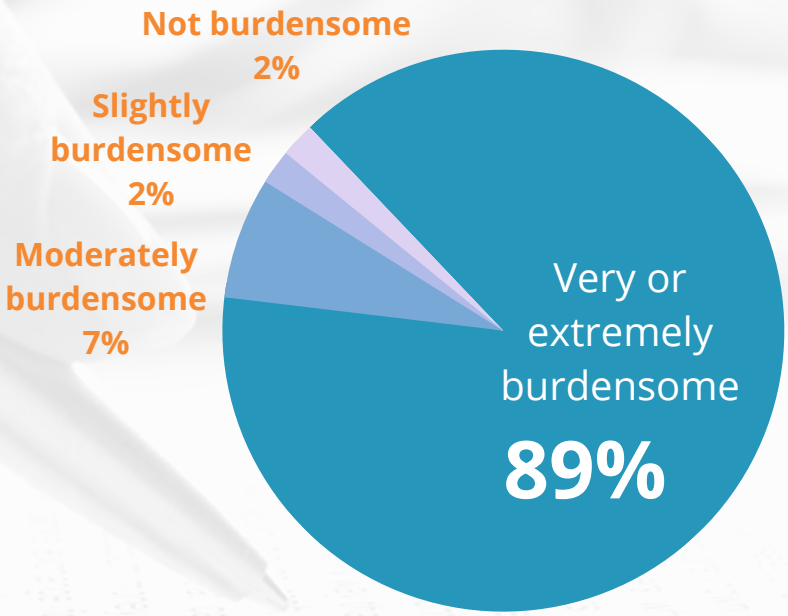
"I have more staff dedicated to administrative duties than I do to patient care."

PRIOR AUTHORIZATION

Utilization management tools, such as prior authorization, not only delay patient care but also increase provider costs and burden. For years, payers have required medical practices to obtain prior authorization before providing certain medical services and prescription drugs to patients. These health plan cost-control mechanisms often delay care unnecessarily at the expense of the patient's health and the practice's resources.

Practices continue to face growing challenges with prior authorization, including issues submitting documentation manually via fax or through a health plan's proprietary web portal, as well as changing medical necessity requirements and appeals processes to meet each health plan's requirements.

How burdensome would you rate prior authorization requirements?



What group practices are saying:

"We have 20 physicians in our organization. I have six full time prior authorization staff and it's difficult to get ahead and obtain the PA's two weeks out."

"The amount of reporting and authorizations continue to increase, taking time and man power away from actually providing care and patient satisfaction. Another thing that becomes more complex year after year are the coding requirements. Each payer group implements their own requirements, modifiers, alternate codes, etc., that an EHR cannot accommodate and must be manually appended by staff."

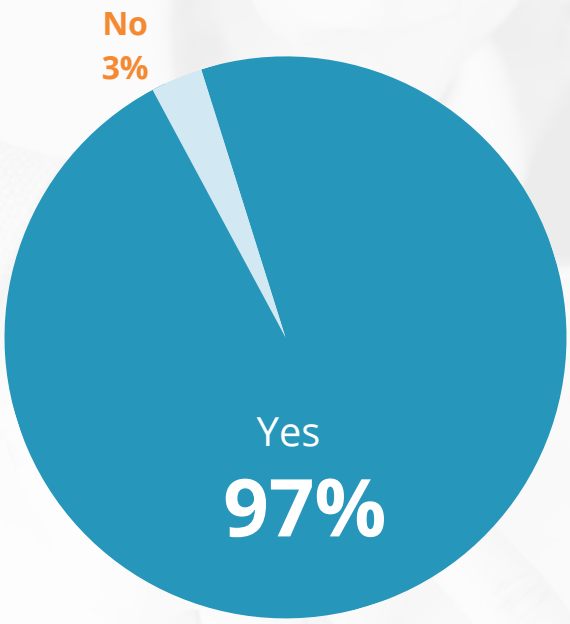
"We have had to hire another FTE just to do prior authorizations and she still can't do all of them. Other staff have to fit them into their daily work as well."

"It delays patients' access to care. Some payers take over two weeks to respond, some do not respond at all, and providers must waste time chasing them down for an answer."

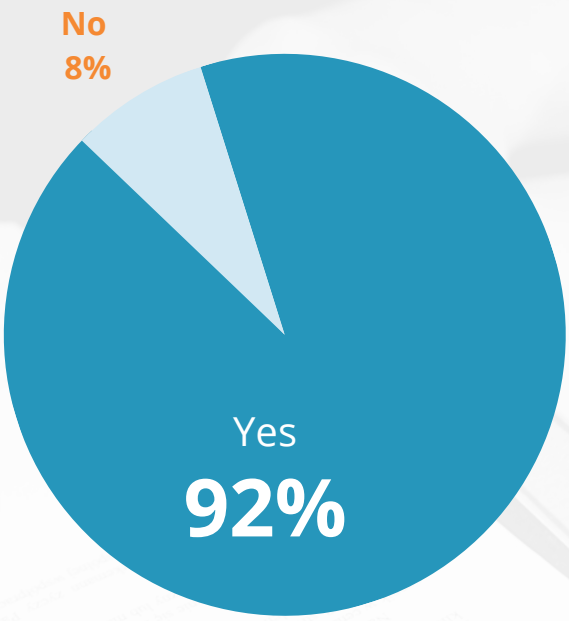
PRIOR AUTHORIZATION (CONT.)

With an increase in utilization of prior authorization across both commercial payers and Medicare Advantage, practices are struggling to ensure patients continue to maintain access to medically necessary care. Prior authorization processes can vary greatly across payers, resulting in a convoluted and overly burdensome process. Ninety-two percent of practices have had to hire additional staff or redistribute current staffing resources to process prior authorizations due to the increased number of requests.

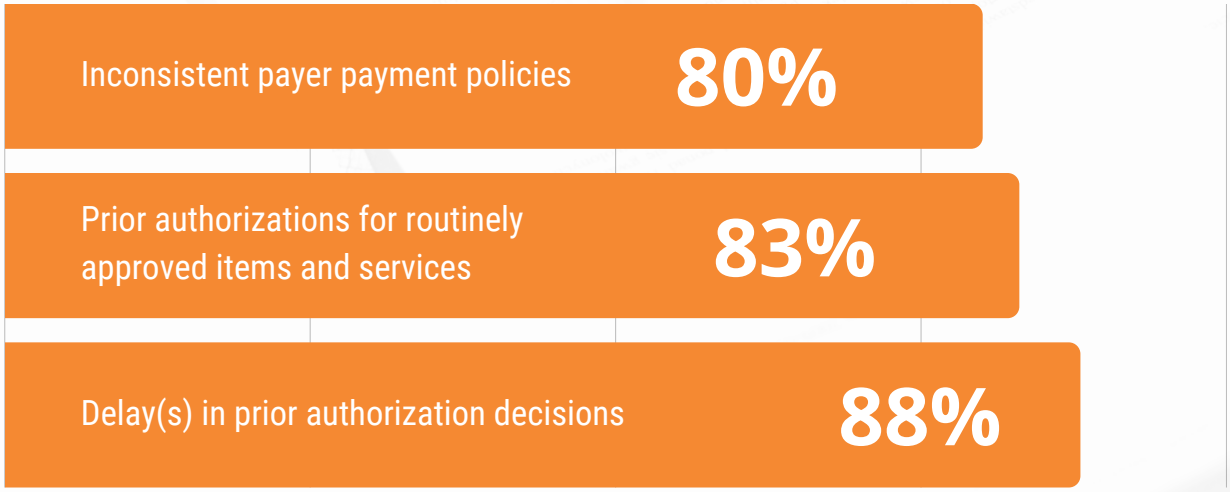
Have your patients experienced delays or denials for medically necessary care due to prior authorization requirements?



Has your practice hired or redistributed staff to work on prior authorizations due to the increase in requests?



Top Challenges with Prior Authorization

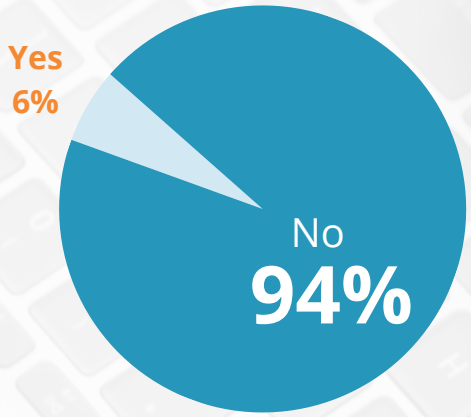


QUALITY PAYMENT PROGRAM

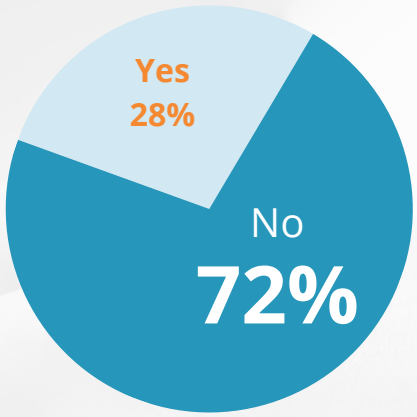
The Quality Payment Program (QPP) created two new reporting pathways to transform care delivery for Medicare beneficiaries by incentivizing the highest quality care, the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

In 2023, 69% of respondents are participating in MIPS. It is generally seen as a complex compliance program that focuses on reporting requirements rather than an initiative that furthers high-quality patient care. CMS introduced MIPS Value Pathways (MVPs) for voluntary reporting in 2023 to further transition practices into value-based care arrangements. Eleven percent of practices responded that they are currently reporting under an MVP, while 89% report not voluntarily reporting under an MVP due to either not having an MVP clinically relevant to their practice, choosing to continue under traditional MIPS, or not understanding MVPs.

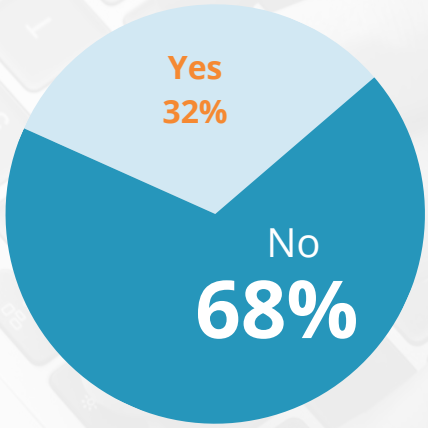
Has the move toward value-based payment initiatives (in Medicare/Medicaid) lessened the regulatory burden on your practice?



Has the move toward value-based payment initiatives (in Medicare/Medicaid) improved the quality of care for your patients?



Overall, has the move toward paying physicians based on value been successful to date?

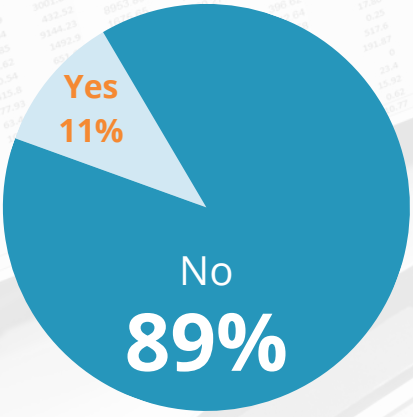


QUALITY PAYMENT PROGRAM: MIPS

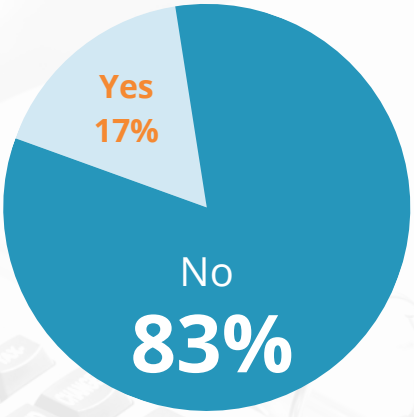
Current quality reporting programs require medical groups to report a large number of measures, but they are often not drivers of meaningful improvements. MGMA has longstanding concerns that MIPS cost measures unfairly penalize clinicians and group practices for costs over which they have no control. MGMA regularly hears from members that clinicians and group practices do not understand how CMS evaluates them on MIPS cost measures and that the lack of actionable, timely information makes this category a "black box" that they have little to no control over.

Is CMS' feedback actionable in assisting your practice in improving clinical outcomes or reducing healthcare costs related to the...

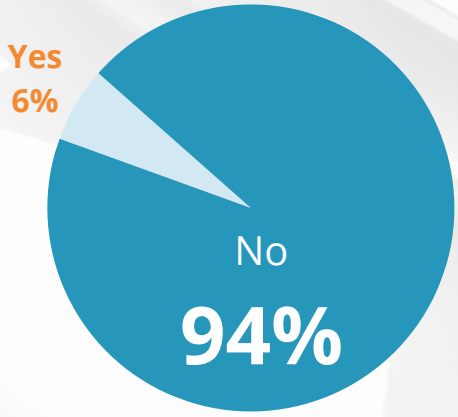
...cost performance category?



...quality performance category?



Do positive payment adjustments cover the costs of time and resources spent preparing for and reporting under the MIPS program?



What group practices are saying:

"The MIPS program is a significant burden on our providers, who routinely complain about the measures not applying to the clinical care they are providing the patient. In many cases, the information being a pain is duplicative (managed by another provider), and our patients are very dissatisfied with the constant requests for the same information across multiple specialties."

"The cost category is unclear and arbitrary. As a Primary Care Provider office, it feels like we have no control over the cost category because there are so many outside factors."

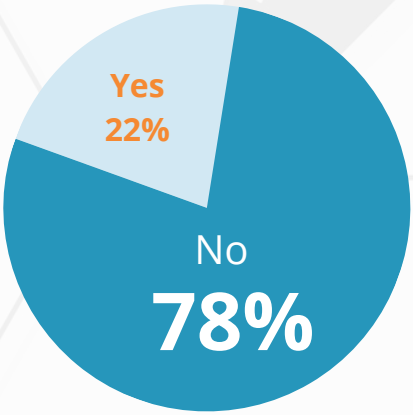
"A constant 'moving the goal posts' after the data collection year is very frustrating. We don't know what we will be truly measured on until after the year is complete."

QUALITY PAYMENT PROGRAM: APMs

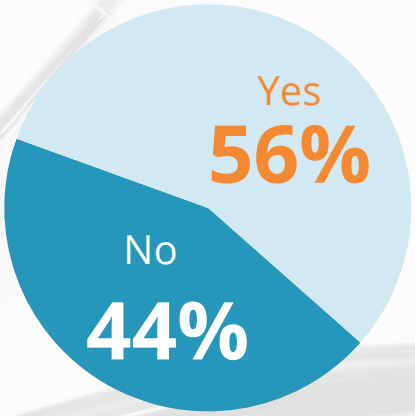
The goal of APMs is to improve quality of care or patient outcomes without increasing spending. The *Medicare Access and CHIP Reauthorization Act* (MACRA) was passed to incentivize participation in APMs. This landmark legislation also created MIPS as an alternative quality pathway, which was intended to be an on-ramp to APM participation.

MGMA has expressed concerns that the Center for Medicare and Medicaid Innovation (CMMI) does not offer enough APM models to reflect the full breadth of specialties. There is no one-size-all-approach to APM design as different specialties are responsible for the provision of different types of care. The Physician-Focused Payment Model Technical Advisory Committee (PTAC) has recommended numerous models for testing, but not one has been adopted by CMMI to date. Within the current portfolio of APM offerings, a majority of MGMA practices do not have a clinically appropriate model in which to participate.

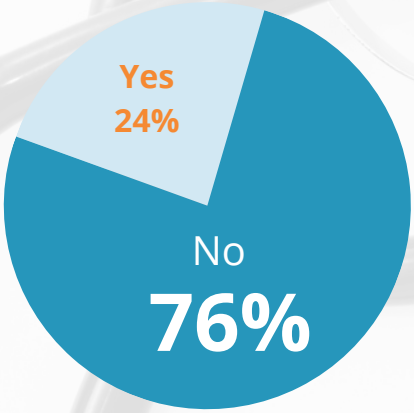
Does Medicare offer an Advanced APM that is clinically relevant to your practice?



Would your practice be interested in participating in an Advanced APM if it was clinically relevant and aligned with your quality goals?



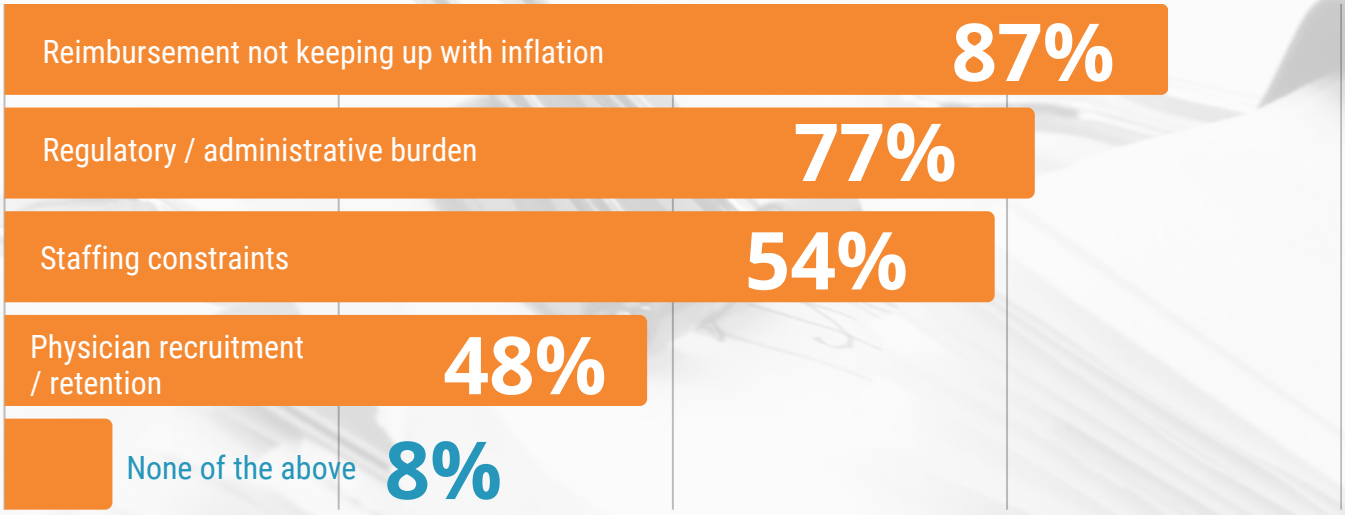
Do you anticipate that your practice will achieve Qualifying APM Participant (QP) status for the 2023 performance year?



ACCESS TO CARE

Year over year, medical groups face increasing regulatory and administrative burden in their practices. In the wake of physician workforce shortages, and an increasing Medicare population, medical groups report struggling to maintain access for patients with traditional Medicare. Reimbursement not keeping up with inflation, regulatory and administrative burden, staffing constraints, as well as physician retention and recruitment, were cited as impacts to current and future Medicare patient access.

Which of the following impacts current and future Medicare patient access?



What group practices are saying:

"Our specialty's patient population is less than 15% commercial. We have identified and increased our non-clinical staff significantly just to keep up with prior authorization and Medicare Advantage requests. We have eliminated service lines that our patients benefit from due to the complexities, time commitment, and staffing costs required to authorize these services despite being the clear right provider of the service, to the right person at the right time, in the right place."

"Between the reimbursement cuts and increasing regulatory costs, keeping the doors open becomes more challenging daily."

"Much needed rural safety net clinics can barely survive. A significant portion of the operational grants that keep us afloat must be applied to regulatory work rather than direct patient care."

SURVEY PARTICIPANT DEMOGRAPHICS

How many full-time-equivalent (FTE) physicians are in your organization?	
1-20	60%
21-50	14%
51-100	9%
101+	16%

Which of the following best describes your organization's specialty focus of care?			
Allergy/immunology	<1%	Neurology	1%
Anesthesiology	1%	Neurosurgery	1%
Cardiology	3%	OB/GYN	3%
Critical care	0%	Ophthalmology	3%
Dermatology	5%	Oncology	1%
Emergency medicine	2%	Orthopedic surgery	7%
Endocrinology	1%	Otolaryngology	4%
Family practice	14%	Pain management	2%
Gastroenterology	5%	Pathology	1%
General surgery	1%	Pediatric medicine	4%
Geriatrics	<1%	Psychiatry	1%
Infectious disease	<1%	Radiology	1%
Internal medicine	2%	Rheumatology	3%
Multispecialty w/ primary & specialty care	18%	Urology	1%
Multispecialty w/ specialty care only	1%	Other	9%
Nephrology	2%		

Which of the following best describes your organization?	
Independent medical practice	75%
Hospital or integrated delivery system (IDR), or medical practice owned by hospital or IDS	14%
Medical school faculty practice plan or academic clinical science department	4%
Management services organization (MSO)	1%
Physician practice management company (PPMC)	2%
Independent practice association (IPA)	2%
Other	3%

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